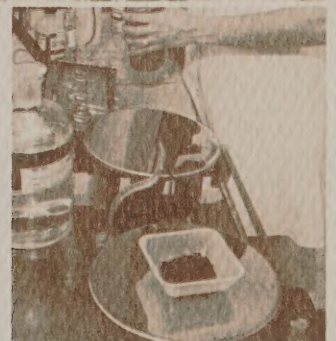


New England Deaconess Hospital 1973 Annual Report



The President's Message

C. Vincent Vappi
President



This, the first year I have served as President of the Deaconess Hospital, has been an exciting year for me, and I believe a truly eventful year for the Deaconess Hospital. Although the Deaconess has a new President, the challenge of responding wisely to these events, of shaping policy to best position ourselves to meet future events, and of maintaining the excellence of the quality of individual patient care in the Hospital is largely the responsibility of the Executive Committee of the Board of Trustees. Following eight years of inspired leadership as President, Mr. Laurens MacLure remains a very active participant in the affairs of the Deaconess, as Chairman of the Board of Trustees, member of the Executive, Budget, Investment, and Long-Range Planning Committees, and unofficial counselor to the President and Executive Vice President whenever his wisdom and experience are needed. In addition, such long term members of the Deaconess family as Treasurer Henry Rogerson, Vice Presidents James Farr and Colby Hewitt, Jr., Clerk James Mountz and Budget Committee Chairman Albert Pratt have continued their valuable service on the Executive Committee.

I stated that this has been an eventful year for the Deaconess Hospital. Among the more significant events have been:

—Arrangement for a \$14,900,000 financing through the Massachusetts Health and Educational Facilities Authority to cover past and current physical plant expansion.

—Reaffirmation of our commitment to the Deaconess School of Nursing coupled with a decision to construct, when necessary approvals and financing are in hand, a completely new school facility on Hospital property bounded by the Riverway, Longwood Avenue and Autumn Street.

—Continuance of the high demand for Deaconess services resulting in virtually full occupancy, but ironically sustaining an operating financial loss due to restraints placed on us under regulations of the Federal Cost of Living Council, which many regard as inequitable and discriminatory.

—Recommendation by the Long-Range Planning Committee, and subsequent endorsement by the Medical Administrative Board and approval by the Executive Committee, of "A Proposal for Meeting

Long-Range Objectives of the New England Deaconess Hospital".

—Establishment of the base of Harvard Medical School's Fifth Surgical Service directed by Dr. William V. McDermott at the Deaconess Hospital, under a teaching program to be known as "The New England Deaconess-Harvard Surgical Service".

Expanding on some of these events, the \$14,900,000 financing was arranged primarily to provide funds for the construction of our new laboratory building on the site of Norwich House at the corner of Pilgrim Road and Francis Street. The building will contain new Clinical Laboratory and Radiation Therapy facilities, and will contain 57,520 square feet of gross floor area on seven levels, and will relieve some of our most overcrowded and inadequate present space. After many months of delay, we were finally successful in obtaining our Certificate of Need from the Public Health Council of Massachusetts on April 10, 1973, and were then in a position to seriously seek financing. Having already received competitive bids from seven contractors, the project cost was known to be \$6,254,000. Consideration of alternative methods of financing led us to the conclusion that the Massachusetts Health and Educational Facilities Authority offered the most favorable opportunity for obtaining funds, by reason of lower tax exempt interest rates and the fact that 100% of the project cost could be financed. During the course of negotiating this financing, it appeared advantageous to obtain the \$2,000,000 of permanent financing for the recently completed garage, to replace the existing \$3,500,000 mortgage on the Farr Building and to fund \$500,000 of new equipment from the same source. These costs, plus certain reserves, aggregated to a \$14,900,000 package which, in the form of tax exempt revenue bonds, was sold in mid October 1973 at a net interest cost of 5.61%. The construction contract was immediately executed, and if all goes well, the facility will be completed in April of 1975.

The laboratory building is the second part of our current building program, the parking garage completed in 1972 being the first. The third and last part will be a new school of nursing. The Executive Committee carefully evaluated the long-term viability of the nursing school in the context of changing patterns of education and health care, took note of the prominence and excellence of the Deaconess School of Nursing, and concluded that it was necessary and desirable to support the school. It has been apparent for some time that the physical facilities for the school are far below minimum standards, and that they must be replaced or upgraded if the school is to continue. Alternative plans for accomplishing this were considered, and the soundest long-term strategy appeared to be to construct a completely new facility, including residential space, classrooms and offices, on our property at the corner of the Riverway and Longwood Avenue.

Preliminary estimates indicate a project cost of approximately \$4,000,000, of which \$2,500,000 will be available through a grant from The Frederick J. Kennedy Memorial Foundation, Inc. We are currently seeking the required certificate of need from the Public Health Council, and if and when we have accomplished this we will proceed forthwith with planning and subsequently with construction.

As Mr. MacLure reported last year, the Long-Range Planning Committee, composed of trustees and members of our medical staff and of our administration, concluded that the future of the Deaconess lies in the area of a specialty referral hospital; that such a future will require a gradually increasing interaction or affiliation with a medical school and that a more cohesive organization of the independent medical staff will be necessary. The move of Harvard Medical School's Fifth Surgical Service to the Deaconess is consistent with this conclusion, as is the development by the Long-Range Planning Committee of "A Proposal for Meeting Long-Range Objectives of

the New England Deaconess Hospital". The Committee's efforts during this past year were largely directed toward developing and refining this proposal, during the course of which every effort was made to explain the proposal to and seek comments from all elements of the Deaconess family. The Committee finally was satisfied that a consensus of support for the proposal had been developed, and upon its recommendation and the endorsement of the Medical Administrative Board, the Executive Committee approved the proposal. The purpose of the proposal is to strengthen the Medical Staff so as to better meet the challenges of the future. To do so, the Chairmen of the Professional Departments must be given the opportunity to recruit physicians from the Medical Staff to meet specific needs, some of whom may be compensated in full by the hospital, and others partly compensated. When expedient, the chairmen of the professional departments should be full-time, and should have sufficient authority for the administration of their departments and for the selection of other members of the Medical Staff to perform necessary administrative functions. Support should be generated for promising young doctors who may be needed as professional resources for the Hospital in the future.

While giving the Chairmen of the professional departments increased authority to shape the future of their departments, the proposal requires that all matters of substance affecting the practice of medicine will be referred to the Medical Administrative

Board for its recommendation, before consideration by the Executive Committee of the Trustees. It is planned that the implementation of this proposal will be gradual and evolutionary, with as little dislocation as possible to the interests of the Medical Staff.

The Long-Range Planning Committee will continue to meet regularly, and is presently determining what subjects it should examine next.

A sincere word of appreciation must be expressed to Mr. Lowry, Mr. Lee and other members of the administration, who have succeeded in keeping the affairs of the hospital in remarkably good order in spite of confusion and inflexibility resulting from frequently changing regulations imposed under wage-price regulations.



The Executive Vice President's Message

R. D. Lowry
Executive Vice President



My report last year began with the statement "Pressure continues unabated". Now in retrospect, 1972's problems were simple child's play as compared with the problems of 1973, and there is every indication that the coming year will be even more difficult because of the overwhelming controls that are being promulgated at both the state and federal levels.

It appears that it will continue to be impossible for us to meet the physicians' demands for beds. During the past year we admitted 14,356 patients as compared with 13,739 the previous year. One floor of the Palmer Building

badly needs renovation, but we were unable to close it down for this purpose last summer, the normal slack period, because the pressure for beds continued at the same high level throughout the year. Almost without exception this past year, each department of the hospital experienced a heavier work load than at any time in the hospital's history.

The application for a determination of need for the proposed facility for laboratories and radiation therapy took approximately two months to prepare. It then took an additional eleven months for positive action to be taken by the Public Health Council. We are having similar experience in attempting to get approval for our proposed new facility for the School of Nursing. I shall not deny that there is a need for planning councils but, because of the long delays being experienced on almost all applications, there is an increase in cost of the carefully thought out and well-documented projects that are ultimately approved.

In June the Boston City Hospital reduced its capacity from 740 to 500 beds. Arrangements were made with the Deaconess and other major hospitals in Boston to accept some of the

patients in the event the reduced number of beds became inadequate, but to date no transfers to the Deaconess have been requested. During the year Harvard Medical School phased out of the Boston City Hospital and the Fifth Surgical Service was transferred to the Deaconess and is now named "The New England Deaconess-Harvard Fifth Surgical Service."

I wish it were possible to be optimistic concerning the coming year, but it is not. Hospitals throughout the nation are in serious danger of being restricted by federal controls so complicated and poorly thought out that many of the hospitals will have to make a choice of reducing patient services or going bankrupt. Federal and state approaches to hospital cost and reimbursement are not realistic. Many hospitals have already reported substantial deficits, heavy borrowing to meet operating costs, and curtailment of services. The proposed regulations require hospitals to live within an overall 7½% increase, in spite of staggering increases in the costs of fuel oil and food and sharp increases in the cost of liability insurance, social security, medical supplies, and in almost every commodity and service that hospitals purchase. Members of the medical profession are now being told how long they can treat their patients in the hospital setting and are limited in the number of ancillary services they may order. Administration and department heads are under severe economic restrictions which makes it difficult and at times impossible for them to equal past performance. Control boards with limited or no experience in medical care or hospital administration are now controlling or denying new

programs which the medical staffs and administration, after careful and educated study, have concluded are vitally necessary for optimum patient care.

But, there is one strong, golden thread that weaves through all of the unpleasantness and holds the New England Deaconess Hospital together as it has for 76 years. That is people — people who are loyal to the hospital and dedicated to the patients that we treat in such great numbers. They know, despite rising costs and threats of service curtailments, that concern and consideration can still be provided in large amounts, and I am truly grateful to all of our personnel for maintaining this spirit.

Two of our long-time officers of the Corporation have stepped down to less demanding positions, Mr. Francis W. Capper, the former Chairman of the Board, and Mr. Henry S. Rogerson, our Treasurer for 17 years. Mr. Capper joined the Corporation as a Trustee in 1932 when the hospital was desperately in need of financial advice. He was named Treasurer two years later and served in that capacity until becoming Chairman of the Executive Committee in 1952. He was elected President of the hospital in 1956 and moved up to Chairman of the Board in 1964 before retiring last year to become an Honorary Trustee.

Mr. Rogerson has been a member of the Corporation and of the Board of Trustees since 1934. He became a member of the Executive Committee in 1942 and Treasurer in 1956, remaining active in both positions until the 1973 annual meeting. Although he has now retired from those positions, he continues to serve the hospital as Trustee and as a member of two financial committees. The hospital is

indebted to both of these men, and I am deeply grateful for the strong support they have always given to administration.

I wish, too, to express my thanks to all the current officers and trustees, the administrative staff and department heads and to Mr. Richard Lee, the Director, who shares all the headaches in equal measure. With their help and with the deeply appreciated help and cooperation of the Medical Staff, the Friends of the Deaconess, the employees, and all who provide support and guidance to our hospital, hopefully the Deaconess can override the present turbulence within the health care industry and continue to serve our patients with the quality of care for which we have always been known.



The Department of Medicine

James L. Tullis, M.D.
Chairman



After several decades of exponential growth in the size, complexity and quality of medical care many hospitals in America have entered an equilibrium period of consolidation during which they may redefine their long range goals. The department of medicine at the Deaconess has reflected this trend in diverse ways. It has ceased its annual extension of the house officer program, as full service coverage is now available for the entire staff. It has limited temporarily its annual increase in medical student teaching in an effort to improve quality at the expense of quantity. And like the departments of medicine in all other hospitals it has tightened its reins on clinical investigation in an effort to adjust to lessened federal research support.

To a limited extent such interruptions of growth are a natural phenomenon. They occur in animate objects and in such materialistic indices as the Dow Jones averages. In the case of the health professions, however, the present pause is not a manifestation of a natural cyclic growth.

Rather it is imposed from without by a vast convergence of social and economic forces. The first is governmental and is of both legislative and executive origin. The health policy of the federal government presently appears predicated on the single goal of the delivery of more health care to more people in less time and at less cost. Although this is a laudable aspiration and can not be faulted with respect to altruism or political realism, there is an apparent concern for such practical aspects as where the skilled medical personnel will come from to fulfill such a charge. Even worse there appears to be a cavalier disregard for the *quality* of the care which will be rendered so long as the *quantity* increases. Even the new PSRO legislation, presumably ordained to control the quality of hospital-based medical care appears to have made a pact with mediocrity early in its gestation. It now concerns itself chiefly with controlling the cost of hospital care by using "acceptable quality" as a standard of measurement. Who is to decide what is "acceptable" for you or for me? Our peers? I hope not. If this had been the standard throughout history, medical practice would still be in the era of the Ptolemies.

The hospital practice of medicine appears to have reached a crossroads. The present economic restraints being placed on hospitals through regulatory controls will result either in a retreat in size or a decrease in quality. Stepwise reduction in the availability of such necessary services as laboratory tests already has begun.

If continued, this will eventually lessen the speed with which diagnoses can be made and thus the quality of the care which can be delivered. To many critics both in and out of the medical profession this will come as good news. They have complained for years about runaway hospital costs. Financial control was what they were after. But such an attitude must be tempered by the results it produces. The moment patient care is regulated by cost analysis rather than medical needs, important ethical and moral issues arise. Moreover, the end result in any type of culture or economy is to return the availability of quality care only to those who can afford it and thus to have an outcome which is the opposite from the one which was sought.

The role of government in financing medical research is even more pragmatic. Research grants for basic studies, the very life blood which has led to unprecedented gains in medical therapeutics and disease control in the mid twentieth century, have been sharply restricted. Simultaneously the training grants which supported young scholars during their transition period from medical school into careers as investigators, have been cancelled. Although this has had the intended result of forcing young doctors out of the laboratory and into the practice of medicine, the analogy to throwing out the baby with the bathwater is too poignant to escape notice. Where will the knowledge come from for the advances of the next decade, if we cannibalize our current assets?

An additional force which is beginning to affect the hospital practice of medicine comes as an amalgam from foundations, the media and diverse social institutions. It consists of consumerism in its most unproductive form and attempts to plant lay controls into the middle of medical care. This cult refers to physicians as "providers". It advocates an ombudsman for every hospitalized patient. It would attach a non-professional advocate to the side of each patient to remind him of his "rights" rather than the unprecedented privileges which he enjoys. Is he sure he wants to be the subject of medical grand rounds and sit in a wheel chair before curious doctors? Does he know that the consent form which he signed before participating in a research study is legally worthless and that a civil suit still may be entered? Does he know that he can demand access to his medical record at any time? Such topics currently are the subject of interdisciplinary discussions and sociologic planning in universities throughout the country.

The mere fact that the previously sacrosanct arena of patient-doctor relationships has been deemed of sufficient public concern to justify a forum of this type suggests that somewhere, some place, practicing physicians have functioned at less than optimal levels. But in large part it also reflects the non-Aristotelian logic of the present consumer-oriented society which debates the food value of Wheaties while simultaneously choosing to ignore the hundreds of thousands of deaths from alcohol, automobiles and cigarettes.

What posture should we, in one small department of a single institution take against such trends? Merely to complain and remain static achieves nothing but a label of conservatism. Should it not be the role of hospital-based physicians to strive to remain a nidus of progress and advancement? If we believe in the future and in the need to educate young men as physicians, teachers and scientists, we must do so regardless of cost. If the federal government

chooses not to support such a function, and they have, we must turn to industry and to our own profession to help underwrite costs. If consumer councils block the expansion of physical facilities of hospitals we must make better use of those which we have. If non-professional groups and individuals attempt to insert themselves between the physician and his patient, let us work to reaffirm the importance of this delicate relationship. The trust of a patient for his personal physician and the equal concern of a well motivated physician toward his sick patient are perhaps the finest attributes that can be taught in a hospital education program. Such relationships can not be encompassed by the terms "provider" and "consumer". It behooves the physicians carefully to take stock and reassert the meaningful personal relationship which they feel for their patients. Equally, they must determine what they need for the best care of their patients and demand its availability for the future. Finally, it is contingent on the administrators of health care and educational systems within hospitals not to accede to any

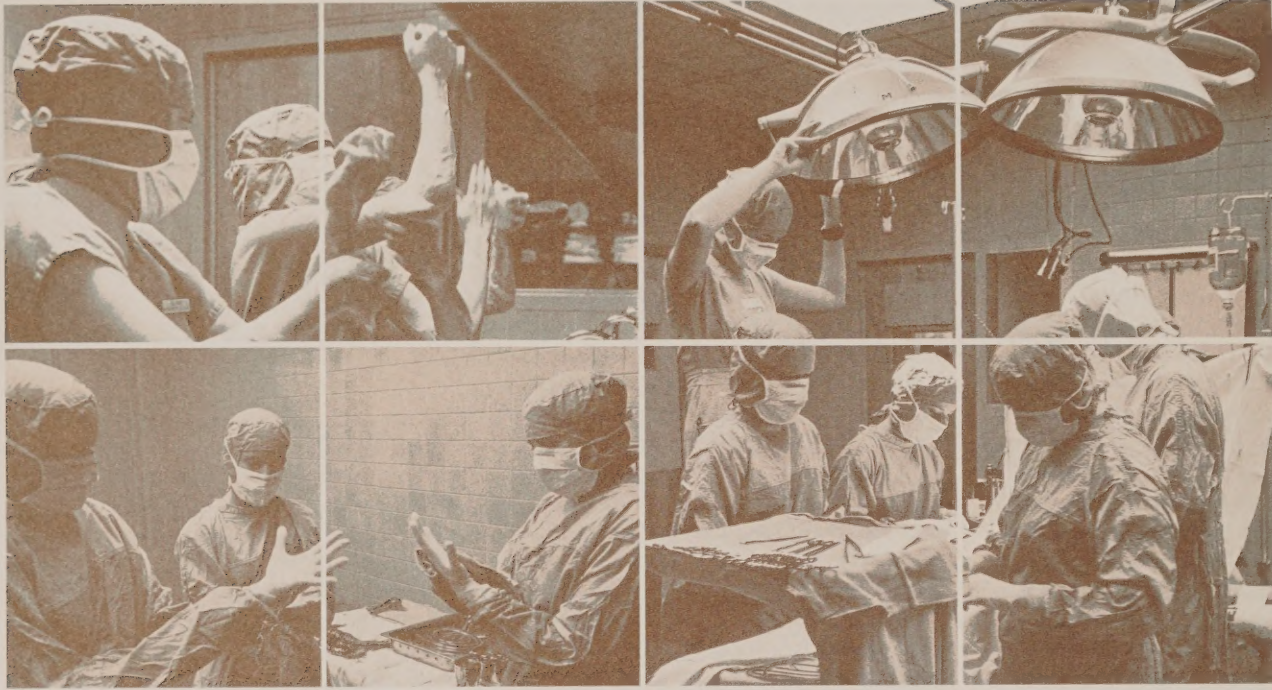
unreasonable demands which threaten to destroy the spirit which built the volunteer hospitals of this country to a position which is unequalled in the world.

Despite the vicissitudes of the society outside our microcosm, we *also* must continue to grow and nurture and change. We also must remain good stewards of the principles and ethics which were given to us by previous generations. Whenever such standards are better than the present we must reject the false premise that change is progressive merely for the sake of change.



The Department of Surgery

Cornelius E. Sedgwick, M.D.
Chairman



The high point for the Department of Surgery this year was the merger or transfer of the Harvard Surgical Service (Fifth Surgical Service) of the Boston City Hospital to the New England Deaconess Hospital. This decision by the Board of Trustees had the full support of the Long-Range Planning Committee, the Medical Administrative Board, and the surgical staff. The importance of this transfer cannot be underestimated. It will have a profound effect on the future of the Department of Surgery.

The development of a surgical residency program at the New England Deaconess Hospital was first studied in depth about 10 to 12 years ago by an Ad Hoc committee appointed by

Dr. Leland McKittrick, temporary chairman of the Department of Surgery. The committee was charged with defining the type of surgical internship and residency training program to be instituted at the New England Deaconess Hospital. After considerable deliberation the committee advised against developing its own internship and residency program because of lack of certain facilities, that is, emergency room, outpatient department, and so forth, but to become affiliated with an approved university medical school program and to have residents rotate to the New England Deaconess Hospital for certain types of surgical training. This was adopted by the hospital, and an agreement was made with Dr. William V. McDermott, Chairman of the Harvard Surgical Service of the Boston City Hospital, to rotate residents to the Deaconess for part of their surgical training. The Harvard Surgical Service also rotates residents to the Mount Auburn, Faulkner, Cambridge City, and the Manchester Veterans Administration Hospitals. This affiliation grew and became im-

portant to both the Harvard Surgical Service and the New England Deaconess Hospital.

Harvard's association with the Boston City Hospital began with the construction of the hospital in 1864 at which time Dr. David William Cheever became its first chief of surgery and Harvard medical students became its first interns. The present director of the Harvard Surgical Service is Dr. William V. McDermott, Jr., who is David W. and David Cheever Professor of Surgery. Because of severe municipal financial astringencies with a consequent reduction in patient population, service, and facilities at the Boston City Hospital, the Harvard Surgical Unit and the Harvard Department of Surgery at the Boston City Hospital were moved to the New England Deaconess Hospital. The New England Deaconess Hospital then became the parent institute of this service which has been named the New England Deaconess Hospital-Harvard Surgical Service. Dr. William V. McDermott, Jr. has been appointed Director of the Cancer Re-

search Institute at the New England Deaconess Hospital. This arrangement allows Doctor McDermott to continue his interests in teaching, research, and clinical surgery.

The New England Deaconess Hospital now has a fully approved university surgical internship and residency program. This carries additional responsibilities: more staff time for teaching must be given to an increased number of both house staff and medical students. Teaching involves not only the teacher and student but also the patient. Some teaching hospitals have placed teaching above patient care. At the New England Deaconess Hospital we must guard against this trend and preserve our traditional emphasis on excellent patient care.

Residency Program

The New England Deaconess Hospital-Harvard Surgical Service residency is a four-year graded program in general surgery and all of its specialties including an opportunity for surgical research, special studies, and foreign travel.

Ten first year residency positions are offered; these will include, in addition to general surgery, a two-month rotation in orthopedics at the Boston City Hospital, gynecology at the New England Deaconess Hospital, and emergency ward experience at the Faulkner Hospital, Cambridge City Hospital, and Mount Auburn Hospital.

Eight second year residency positions are offered and these include, in addition to general surgery, two months' experience in thoracic surgery at the Mount Auburn Hospital and a two-month rotation to the accident floor at the Cambridge City Hospital.

Between the second and third year of residency, each resident is given the opportunity to select a program of special study which may include a period in a research laboratory, special study at Harvard University or other institutions, or foreign travel.

Six third year residency positions and six chief residency positions are

offered. This last 24 months of the residency program is designed as a single unit with increasing opportunities, responsibilities, and experience culminating in the final four months as a senior chief resident at either the New England Deaconess Hospital or the Cambridge City Hospital.

In the third year, individual rotations include thoracic surgery at the Mount Auburn or Deaconess Hospitals, general surgery at the Lahey Clinic Foundation, emergency ward surgery at the Cambridge City Hospital, and general surgery at one or more of the integrated hospitals.

The chief residency will be divided into two pathways. One chief resident will divide his experience into four months at the Mount Auburn Hospital, four months at the New England Deaconess Hospital, and the final four months at the Cambridge City Hospital. The second chief resident will divide his experience into four months at the Veterans Administration Hospital, four months at the Faulkner Hospital, and finally, four months at the New England Deaconess Hospital.



The Department of Cancer Research Institute



The Cancer Research Institute, which has been in operation for 22 years, was founded by Dr. Shields Warren to make available to local physicians the most advanced technologies for cancer diagnosis and treatment. In this age of massive investments in cancer-related activities, a disproportion in scale between the Institute and more recent centers is apparent; however, a continued catalytic role for the small but excellent Institute can still be discerned. Over the years it spearheaded the wide employment of radioactive isotopes in medicine, and the Shields Warren Radiation Laboratory and the Joint Center for Radiation Therapy were part of its spin-off. The Institute is one of 30 members of the Association of American Cancer Institutes and one of 12 American members of the International Union Against Cancer.

Dr. Eugene Knox, Senior Research Associate in the Institute and Professor of Biological Chemistry at Harvard Medical School, served as Acting Scientific Director of the Institute during the absences of Dr. George Nichols.

Research projects in the Institute during 1973 resulted in the publishing of over 30 papers and books:

In the Department of Biochemistry, Dr. Knox's discovery of the chemical similarities between cancers and immature fetal tissue provides the theoretical framework for that most exciting new approach to diagnosis and treatment of cancer through certain fetal antigens.

A Growth Laboratory, headed by Dr. Olga Greengard, Senior Research Associate, was newly organized to facilitate her crucial studies in the area of the control of normal fetal development. These are the regulations that apparently break down in cancer.

The Department of Electron Microscopy, under the leadership of Dr. Micheline Federman, Research Associate, has been able to choose and work out techniques for a model system to observe osteogenesis at the light and electron microscopic levels. The Department defined and distinguished the various cell types in rat calvaria qualitatively at the light microscope level, and in studies with the

electron microscope, a new structure in bone cells, the cilium, was identified. Extremely reliable, solid data on normal development of rat calvaria serves as the basis of a powerful tool for further studies of bone disease in humans.

The Department of Experimental Pathology has continued to focus its attention on radiation carcinogenesis and particularly radiation leukemogenesis. These problems have special interest as the shortage of fossil fuels increases the relative importance of nuclear power plants. Although these have been operating with extraordinarily high levels of safety and do not constitute a present

hazard, it is, nonetheless, increasingly urgent to learn additional details of dose-effect relationships between various levels of radiation exposure and possible carcinogenic effects.

Of special interest was confirmation of the observation that rats are much more resistant to induction of leukemia by radiation than are mice and that low levels of radiation (50 rads) are adequate to induce leukemia in mice. The Department has worked with the Environmental Protection Agency's Bureau of Radiological Health through Dr. Norman Telles to determine the role of past fluoroscopic studies in the development of cancer of the breast. A study of radiation-induced breast cancer in mice has been completed.

Dr. Warren continued as Chairman of the Life Sciences Committee of the National Aeronautics and Space Administration, and under the auspices of Alpha Omega Alpha and the Josiah Macy, Jr. Foundation, he gave an audiovisual taped autobiographical interview on items of medical history with which he had had contact.

Five predoctoral trainees at the Institute are affiliated with the doctoral programs of Boston University or Harvard Medical School, and six postdoctoral trainees from the United States, Spain, Taiwan, Japan, and India broadened their research experience at the Institute during the year.

The activities of the Hospital Tumor Registry, part of the Medical Records Department, were moved during 1973 to the Cancer Research Institute. Maintenance of a Tumor Registry, required by the American College of Surgeons of every hospital certified to treat cancer, ensures that treatment of each patient is followed through over the years that this may be necessary, and it provides an explicit record of the total Hospital experience with different forms of the disease. A National Registry for Phenylketonuria has been maintained for some years in the Cancer Research Institute, and the expertise

gained from that Registry has now been applied to the Tumor Registry. Systems analysis and coding services donated to the activity by the Cancer Research Institute are aiding registry personnel in transforming the Registry into modern form, so that beginning in 1974, the advanced computer facilities of the Deaconess can be used to keep track of these special patients. The system is also being designed to furnish physicians on request with precise details about all previous cases of any given kind.

The research projects of the Institute were supported by funds in the amount of \$1,048,240, received from two contracts from the U. S. Atomic Energy Commission, from grants from the National Cancer Institute, the National Institute of Arthritis, Metabolic and Digestive Diseases, the National Institute of Child Health and Human Development, the General Research Support Grant, from Aid for Cancer Research, John A. Hartford fund.



The Department of Diagnostic Radiology



The Department of Diagnostic Radiology has just concluded its busiest year. Our prediction had been 40,000 examinations. The actual number of examinations performed was 44,843 which is a 14% increase over fiscal 1972. This large increase was not without its problems and it is a tribute to our technical staff that we were able to accomplish the job as smoothly as we did.

Rapid changes are taking place in the practice of medicine. Within this hospital the long-range planning committee has been grappling with the problem of the future of the hospital. Greater involvement as a specialty referral hospital and an ever increasing teaching commitment mean that each department must

gear itself to accomplish these goals. Our own department has reviewed its own teaching program and decided, with approval of the appropriate committees, to offer a fellowship program for young radiologists who would like some additional experience before going out into practice. We will no longer train residents, believing that it is uneconomical to run a small residency program. Rather, with our unusual volume, quality and diversity of pathologic material, we can offer a trained radiologist a most profitable experience.

In July Dr. Daniel McDonald joined our staff. It is of interest that Dr. McDonald was in the first group of medical interns to be trained at the Deaconess Hospital. He brings knowledge and training in the field of ultrasound. This is one of the diagnostic services we will add to better serve the staff and patients of this hospital.

In past reports we have discussed the rapid growth in the diagnostic use of nuclear medicine and scanning techniques. We are now operating the rectilinear scanner ten hours per day and still cannot satisfy the re-

quests of the staff. A scintillation camera will be added this year to satisfy the needs and also to expand the type of examinations to be performed. In a very short period of time the volume of work being performed will require a full-time physician to direct the examinations, interpret the results, and consult with the visiting staff.

Our biggest problem during the past year has been getting reports of X-rays taken to the floors and referring doctors. We have been understaffed in our secretarial pool months at a time. We are still not doing as well as we used to do. In the past we were able to have all X-rays taken up to 2 p.m. reported and on the patient's chart the same day. Three secretaries cannot type 44,000 reports annually, answer the phone, book special procedures, and admit out patients. We must either enlarge our secretarial staff or resort to automation. Several automated systems are currently being used. One system, already available commercially, uses a pre-printed card with various symbols for each examination. The radiologist checks off the appropriate symbols. An optical scanner then reads the symbols and a small computer generates a completed report in eight seconds. Other useful features are the accumulation of better statistics, pathologic files, and charges. This is probably the forerunner of a system where each nursing station will have its own print out of reports generated elsewhere within the hospital.

It would be pleasant to report that we look forward to a busier year in 1974, but medicine is no longer in control of its own destiny. Consumerism is the word of the day. The "Consumer" has decided that spiraling medical costs must be controlled; but he doesn't wish to give up instantaneous service, availability of the newest techniques, and diagnostic and therapeutic equipment. It is frustrating to work under these restricting controls and the excitement of practicing medicine has been diminished.

The Department of Pathology

Bradley E. Copeland, M.D.
Chairman



Due to the dedication and hard work of all members of the Pathology Staff, our Pathology Laboratory produced more units of work than ever before with a limited staff. Our cost to produce one unit of testing increased by only 3% in spite of the larger increases in cost of materials and salaries. The Pathology Laboratories were faced with stringent price control regulations during the latter half of the year which resulted in a no-hire policy for six months. For the first time in twenty years it was necessary to restrict certain services to patients. Since the overall volume of work increased at the same time, every effort was made to insure that the restricted services did not interfere with patient care.

Among the new services which were offered was the all volunteer blood donor program whereby only volunteer blood donors are used. The Red Cross was very helpful in this regard. A concomitant advance in the blood procurement was the development of a Blood Assurance Program for members of the Medical Staff, hospital employees and their

families. It is a program unusual in that it includes grandparents. The Blood Bank also has assumed the responsibility for the frozen blood program developed by Dr. James Tullis. This was a significant cooperative effort between departments.

Our teaching programs for resident physicians, medical technologists, cyto-technologists and Blood Bank Technologists have continued unabated to produce high caliber physicians and technologists. Our undergraduate Medical Technology program with Northeastern University has developed a new format which represents a distinct pioneering effort in the educational field. Many laboratory divisions cooperated in setting up the new admission laboratory which helps to speed up patient care by making laboratory measurements available to the physician very soon after admission.

We are grateful to Drs. Raymond Maguire and Bernard Mann for all their contributions to our laboratory and our patients. We wish them all good fortune in their new positions. We are pleased to welcome to our staff

Dr. Ann Crosson and Dr. Agnes Kim. Our staff has continued to contribute to local, national and international pathology progress. Dr. Merle Legg served this year as President of the New England Society of Pathologists; Dr. William Meissner was Visiting Professor of Pathology at Southwestern Medical School in Dallas and also served as Chairman of the Scientific Advisory Board of the Armed Forces Institute of Pathology; Dr. Copeland received a citation for Outstanding Service from the World Association of Pathology Societies.

The Joint Center for Radiation Therapy

Samuel Hellman, M.D.
Chairman



This has been the fifth year of existence for the Joint Center for Radiation Therapy. During this time, approximately 1,800 new patients were seen. Of these, 510 were seen at the New England Deaconess Hospital.

The member hospitals of the Joint Center remain the Beth Israel Hospital, Boston Hospital for Women, Children's Hospital Medical Center, New England Deaconess Hospital, Peter Bent Brigham Hospital, as well as the Faulkner Hospital, the first Associate member. The personnel of the Joint Center now numbers 95. This year has been the first year of operation of the new 12 MeV linear accelerator added to the Joint Center for Radiation Therapy department at the Peter Bent Brigham Hospital. This has greatly helped in alleviating the

excessive press on our facilities. It is interesting to note that as we have expanded, we find that we are running very close to capacity again. We, therefore, look forward to the prompt completion of the new radiation therapy department at the New England Deaconess Hospital. This will be a new facility which will coordinate and expand the radiation therapy service within the New England Deaconess Hospital and will represent a major physical component of the Joint Center for Radiation Therapy. It is anticipated that this will have two linear accelerators, extensive facilities for patient examination, and appropriate physics support. This division is so planned that it will fully integrate with the other parts of the Joint Center at the other member hospitals. This will avoid unnecessary duplication and allow the most efficient utilization of personnel and equipment throughout the Joint Center for Radiation Therapy.

The Radiation Therapy Treatment Planning Center at the Parkway Division of the Boston Hospital for Women has now been in existence for

a year and one-half and has been quite successful. The treatment planning for all patients, regardless of the hospital or origin, is being done at the Treatment Planning Center. Most patients are required to go to the Planning Center for measurements or treatment simulation. Housed at the Planning Center is the radiation therapy simulator which allows duplication of the treatment by using diagnostic x-ray facilities in order to follow the exact location of the treatment. In addition, there is an ultrasound scanner for tumor localization, and a variety of shops for fabrication of beam modifying devices made to order for individual patients. Most recently, a treatment planning computer has been added so that all treatment for patients from any member hospital is now being performed at the Planning Center.

The staff of the Joint Center for Radiation Therapy includes nine physicians, three of whom spend a significant period of their clinical activity at the New England Deaconess Hospital. These are Stanley E. Order, M.D., Director of the New England Deaconess Hospital Division of the

Joint Center for Radiation Therapy; Anthony J. Piro, M.D., and J. Robert Cassady, M.D.

The teaching activities of the Joint Center for Radiation Therapy continue to expand. Currently, the residency program has ten residents. The chief resident last year, Dr. William U. Shipley, was awarded a Mosely Travelling Fellowship from Harvard University. One of these is given out yearly to outstanding graduates of Harvard University who show great promise in academic medicine. Dr. Shipley is continuing his study of radiation therapy and cancer research at the Royal Marsden Hospital and Institute for Cancer Research in London.

There is a dire shortage of radiation physicists and radiation therapy technologists. In order to help alleviate this, active training programs in both areas continue. At the present time, there are nine trainees in the program for Radiological Physics which is run as a collaborative adventure between our department and the Harvard School of Public Health. There are six technologists in training in our program.

The research areas of the Joint Center for Radiation Therapy are performed primarily in the Shields Warren Radiation Laboratories. The major areas under investigation are described below.

Immunology of an Experimental Tumor

Drs. Stanley E. Order and Robert Knapp have been studying an experimental ovarian carcinoma in mice. They have shown that this tumor has a tumor-associated antigen. Antisera can be specifically made to this tumor; and such antisera, when made in rabbits, has been successful in curing this tumor in experimental animals. They are currently determining the most effective method of giving this therapy as well as beginning to understand its mechanism of action. It is planned that such experiments may allow the successful clinical use of such an antiserum.

The Immunology of Hodgkin's Disease

Drs. Order and Hellman continue their work in understanding antigens associated with Hodgkin's disease. Particularly, these antigens have been further purified this past year. Their location within the tumor and their presence in other non-Hodgkin's lymphomas have been described. It appears that at least one of these antigens is closely related to the lymphocytes derived from the thymus; and if this continues to be so, this will further our understanding of the pathogenesis of this disease. Dr. William Bloomer has been working in the laboratory investigating the problem of whether radioactive material can be attached to the antisera for possible diagnostic and therapeutic purposes. This program has promise and may have important clinical implications.

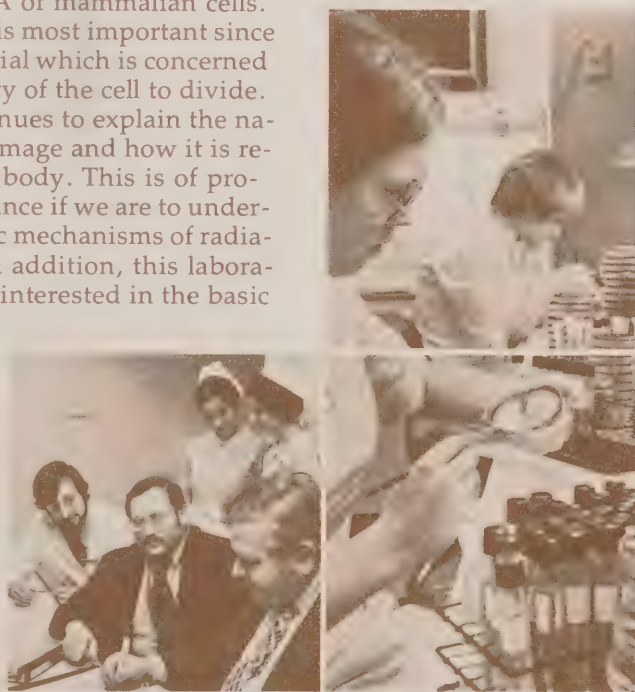
X-Ray Damage of Mammalian Cells and Its Possible Repair

Dr. James A. Belli has been studying the damage which radiation inflicts upon the DNA of mammalian cells. Such damage is most important since it is this material which is concerned with the ability of the cell to divide. Dr. Belli continues to explain the nature of this damage and how it is repaired by the body. This is of profound importance if we are to understand the basic mechanisms of radiation action. In addition, this laboratory has been interested in the basic

radiochemical events which occur when cells and tissues are irradiated. This laboratory has added two new staff people: Professor John Lett, Visiting Professor from Colorado State University, will be working with Dr. Belli on radiochemistry and Dr. Patricia Henson, a new member of our staff; especially expert in DNA biochemistry.

X-Ray/Chemotherapy Interactions

Drs. Anthony J. Piro and James A. Belli have been studying the mechanisms of interaction between some clinically-used chemotherapeutic agents and x-ray in order to understand how best to combine these agents to maximize damage to tumors while minimizing normal tissue damage. They have been studying the drug Actinomycin D and Adriamycin, two important chemotherapeutic agents.



Studies of Hematopoietic Tissues

Drs. Hellman and Nelson have been studying the ability of bone marrow to support the growth of hematopoietic cells after they have been irradiated. This is important since it is the bone marrow that is often a dose limiting normal tissue. New studies are currently under way to understand how the bone marrow responds to radiation or other cytotoxic agents by producing more basic primitive cells. This is important if we are to stimulate the bone marrow to make up for the losses caused by radiation or chemotherapy.

Biology of Normal and Transformed Lymphocytes

Drs. Timberlake, Belli, and Hellman have been studying lymphocytes under a variety of physiologic circumstances, including both resting and proliferating lymphocytes. Such lymphocytes have been shown to be more sensitive to radiation than other cells. Most specifically, their DNA seems to be much more fragile than that of other somatic cells. They seem to suffer more damage from a given dose of radiation, and don't repair as well. This information is important if we are to understand the effect of radiation on lymphocytes and their tumors (lymphomas) in patients.

Studies of the Possible Use of Protons

Drs. Bengt Bjarngard and Goran Svensson have been concerned with the possible clinical applications of the Harvard Cyclotron. They have been studying the beam produced by this in an effort to make this a clinically useful beam. Great progress has been made in this area, and it is hoped that within the next year patients will be started on fractionated radiotherapeutic treatment.

Mechanisms of Increasing Dose to the Tumor While Decreasing Normal Tissues

Expansion of our understanding of treatment planning with the use of the new treatment planning computer as well as design of appropriate beam modifying devices continues. The purpose of these activities is to maximize the dose to tumors while minimizing the dose to normal tissue.

In summary, clinical responsibilities and facilities for patient treatment have continued to increase in this fifth year of the Joint Center for Radiation Therapy. The training programs are now the largest in New England providing for the training of physicians, physicists, and technologists. The multidisciplinary laboratory activities of the Joint Center have been expanded with a number of clinical tumor-related activities currently under investigation, all related to the eventual goal of improved treatment for patients with malignant disease.



The Friends of The Deaconess

Mrs. John L. Rowbotham
President



The Friends of the Deaconess Hospital have had an active and profitable year, raising through their various projects a total of \$46,047.65. The following is a break down of these projects:

Membership	\$ 1854.00
Membership Gifts	2642.00
Memorial Gifts	5120.00
Church Gifts	1501.90
Thrift Shop	17,083.87
Coffee Shop	5426.72
Flower Shop	565.89
Gift Shop	6165.51
Christmas Bazaar	3611.96
Evening at Pops	2075.80

All of the activities of the Friends are not just for the raising of funds. The Diversional Therapy volunteers visited the floors three days a week throughout the year, offering new and interesting hand work to patients, as well as giving them instructions and encouragement. At Christmas time Open House was held in the Farr Lobby for patients'

visitors, employees and staff. In May the annual luncheon was held for all members of the Friends, at which time they heard reports from committee chairmen and about hospital affairs from Mr. Lowry and other members of the administration.

The year 1973 was marred with the unhappy decision to close the Coffee Shop — one of our major sources of revenue. During the twenty years of the Coffee Shop's existence, it enabled the Friends to turn over to the hospital \$212,000.00. As was pointed out by a former President of the Friends, Mrs. Lauriston Ward, Jr., in her annual report, the Coffee Shop faced two problems in 1971 which were likely to increase in the coming years. "The first is the steady rise of food prices. The second is that, faced with a dearth of volunteers, the Coffee Shop gradually has had to increase the number of paid workers." Her words were prophetic. In May the Board of the Friends voted to turn the management of the Coffee Shop over to hospital administration.

This summer two familiar faces — faithful employees in the Gift Shop left the scene — one through illness and one through retirement. The Gift

Shop continues to operate aided by the services of volunteers, some who have served in the Gift Shop over the years and some who had served so faithfully in the Coffee Shop. The Gift Shop is operating at the present time with one full-time and one part-time paid workers; but on a five day instead of a six day work week.

Another very thriving Friends fund-raising activity — the Thrift Shop — continues to be an ever-fascinating and rewarding project for both volunteers and the hospital. This project provides those who donate saleable articles of clothing and bric-a-brac with an income tax deduction. This is truly a mutually profitable venture — for the thoughtful donor, for the interested customer, for the faithful and dedicated volunteer, and for the hospital that provides the shop space. Without one or all of these, there would be no Thrift Shop. This year the "joint venture" realized a profit of \$17,150.00.

The School of Nursing has been a favorite recipient of the Friends projects. This year the Friends provided full scholarships to six nursing students. The total of these scholarships amounted to \$9,500.00. The profits from the annual Christmas Bazaar and the Evening at Pops traditionally go to the School of Nursing. This was true this year too and these monies were augmented by donations from 127 United Methodist Women's Societies to help provide the scholarships for these six deserving nursing students.

Over the past forty years the purpose of the Friends of the Deaconess has remained relatively unchanged. The major concern has been raising funds for the hospital and its school of nursing. Through projects conceived and executed by volunteers, the Friends have given the New England Deaconess Hospital a little over \$878,000.00. I hope the Friends can continue to serve the hospital both financially and by carrying the message of the Deaconess to the surrounding communities.

Balance Sheet

SEPTEMBER 30, 1973 AND SEPTEMBER 24, 1972

	ASSETS	
	Unrestricted Funds	
	1973	1972
CURRENT ASSETS:		
Cash	\$ 936,650	\$ 209,467
Temporary cash investments	884,817	517,217
Accounts receivable — less allowance for uncollectible accounts: 1973, \$1,103,133; 1972, \$804,888 (Note 1)	4,608,375	3,968,088
Grant receivable	400,000	400,000
Inventories of supplies — at cost	276,514	297,783
Prepaid expenses	160,170	125,136
Total current assets	7,266,526	5,517,691
TRUSTEE DESIGNATED FUNDS:		
Cash	742,294	641,851
Temporary cash investments	470,474	394,458
Investments — at cost (market value: 1973, \$176,816; 1972, \$182,863)	173,433	181,363
Total trustee designated funds	1,386,201	1,217,672
DEFERRED REFINANCING COSTS (Note 3)	33,700	
PROPERTY, PLANT, AND EQUIPMENT — At cost (Notes 2 and 3):		
Construction in progress	467,804	503,346
Land, buildings, and equipment — less accumulated depreciation: 1973, \$10,212,722; 1972, \$9,325,826	20,664,445	20,670,812
Total property, plant, and equipment	21,132,249	21,174,158
TOTAL	\$29,818,676	\$27,909,521
	Restricted Funds	
SPECIAL PURPOSE FUNDS:		
Cash	\$ 280,987	\$ 187,251
Investments — at cost (market value: 1973, \$463,353; 1972, \$509,102)	399,727	445,910
Grants receivable	296,187	403,120
Total special purpose funds	\$ 976,901	\$ 1,036,281
ENDOWMENT FUNDS:		
Cash	\$ 192,265	\$ 8,371
Investments — at cost or contributed value (market value: 1973, \$2,711,378; 1972, \$2,935,964)	2,366,584	2,452,029
Real estate, equipment, and furnishings — at cost, less accumulated depreciation: 1973, \$995,457; 1972, \$892,469 (Note 4)	4,137,764	4,213,338
Total endowment funds	\$ 6,696,613	\$ 6,673,738
PLANT REPLACEMENT AND EXPANSION FUNDS:		
Temporary cash investments	\$ 77,069	\$ 133,634

See notes to financial statements.

LIABILITIES AND FUND BALANCES

	<u>Unrestricted Funds</u>	1973	1972
CURRENT LIABILITIES:			
Accounts payable and accrued liabilities	\$ 3,231,691	\$ 2,330,830	
Deferred revenue	274,832	209,805	
Current mortgage note instalments (Note 3)	6,202	72,004	
Advances from third-party payors (Note 1)	400,973	456,100	
Total current liabilities	3,913,698	3,068,739	
 DEFERRED REVENUE — Third-party reimbursement (Note 2)	 583,400	 511,400	
 LONG-TERM MORTGAGE DEBT (Note 3)	 5,372,048	 4,858,027	
 FUND BALANCES	 19,949,530	 19,471,355	
 TOTAL	 \$29,818,676	 \$27,909,521	
 <u>Restricted Funds</u>			
SPECIAL PURPOSE FUNDS:			
Accumulated unexpended gifts and bequests, etc.	\$ 709,275	\$ 661,511	
Unexpended research grants	267,626	374,770	
Total special purpose funds	\$ 976,901	\$ 1,036,281	
 ENDOWMENT FUNDS:			
Mortgage note payable (Note 4)	\$ 2,449,268	\$ 2,534,246	
Fund balances	4,247,345	4,139,492	
Total endowment funds	\$ 6,696,613	\$ 6,673,738	
 PLANT REPLACEMENT AND EXPANSION FUNDS:			
Fund balances	\$ 77,069	\$ 133,634	

See notes to financial statements.

Statement of Revenues and Expenses

FOR THE FISCAL YEARS ENDED SEPTEMBER 30, 1973 (53 WEEKS)
AND SEPTEMBER 24, 1972 (52 WEEKS)

	1973	1972
PATIENT SERVICE REVENUE	\$29,465,542	\$25,429,874
LESS — Free care (net of related endowment fund income of \$61,686 in 1973 and \$59,739 in 1972), provision for uncollectible accounts, contractual adjustments, etc.	2,645,924	1,658,536
NET PATIENT SERVICE REVENUE	26,819,618	23,771,338
OTHER OPERATING REVENUE:		
Transferred from special purpose funds (Note 1)	1,005,996	862,368
Miscellaneous	510,702	503,494
Total other operating revenue	1,516,698	1,365,862
TOTAL OPERATING REVENUE	28,336,316	25,137,200
OPERATING EXPENSES:		
Professional care of patients:		
General	6,851,312	5,954,682
Special	10,136,536	8,896,912
Household and property	2,116,069	2,154,733
Dietary	1,869,843	1,569,757
General services and administration	3,239,588	2,925,555
Employee benefits (Note 5)	2,133,837	1,668,772
Depreciation (Note 2)	1,079,136	1,059,931
Research, etc.	1,005,996	862,368
Interest	221,863	228,450
Total operating expenses	28,654,180	25,321,160
LOSS FROM OPERATIONS	317,864	183,960
NON-OPERATING REVENUE:		
Net income from endowment funds	138,594	103,412
Net income (loss) from operation of parking garage, etc.	(134,876)	16,787
Donations and other distributions (net of expenses of development department of \$42,115 in 1973 and \$57,687 in 1972)	116,716	127,365
Income from temporary investments, etc.	79,354	44,624
Total non-operating revenue	199,788	292,188
EXCESS (DEFICIENCY) OF REVENUES OVER EXPENSES	\$ (118,076)	\$ 108,228

See notes to financial statements.

Statement of Changes in Fund Balances

FOR THE FISCAL YEARS ENDED SEPTEMBER 30, 1973 (53 WEEKS)
AND SEPTEMBER 24, 1972 (52 WEEKS)

	 Restricted Funds			
	Unrestricted Funds	Special Purpose Funds	Endowment Funds	Plant Replacement and Expansion Funds
BALANCE, SEPTEMBER 26, 1971	\$18,139,980	\$ 827,613	\$3,605,440	\$ 28,092
INCREASES (DECREASES):				
Legacies, gifts, etc.	663,215	142,844	93,886	318,062
Central Building Fund receipts				281,395
Grants for specified purposes		907,180		
Net gain on sales of investment securities		45,059	330,074	
Gain on sale of real estate to Unrestricted Funds			130,492	
Investment income		20,869		701
Excess of revenues over expenses for the year	108,228			
Transfer to other operating revenue		(862,368)		
Total	18,911,423	1,081,197	4,159,892	628,250
INTERFUND TRANSFERS:				
Investment in buildings and equipment	559,932	(65,316)		(494,616)
Other		20,400	(20,400)	
BALANCE, SEPTEMBER 24, 1972	19,471,355	1,036,281	4,139,492	133,634
INCREASES (DECREASES):				
Legacies, gifts, etc.	286,834	156,447	115,036	13,300
Building fund receipts				216,987
Grants for specified purposes		785,162		
Investment income		34,150		749
Net loss on sales of investment securities		(7,327)	(7,183)	
Excess of expenses over revenues for the year	(118,076)			
Transfer to other operating revenue		(1,005,996)		
Total	19,640,113	998,717	4,247,345	364,670
INTERFUND TRANSFERS — Investment in buildings and equipment	309,417	(21,816)		(287,601)
BALANCE, SEPTEMBER 30, 1973	\$19,949,530	\$ 976,901	\$4,247,345	\$ 77,069

See notes to financial statements.

Statement of Changes in Financial Position of Unrestricted Funds

FOR THE FISCAL YEARS ENDED SEPTEMBER 30, 1973 (53 WEEKS)
AND SEPTEMBER 24, 1972 (52 WEEKS)

	1973	1972
FUNDS PROVIDED:		
Operations:		
Loss before non-operating revenue	\$ (317,864)	\$ (183,960)
Add items included in operations not requiring funds:		
Depreciation	1,079,136	1,059,931
Increase in deferred third-party reimbursement (Note 2)	72,000	143,400
Total from operations	833,272	1,019,371
Non-operating revenue	199,788	292,188
Total from operations and non-operating revenue	1,033,060	1,311,559
Unrestricted legacies	286,834	663,215
Increase in long-term mortgage debt (Note 3)	520,223	4,392,881
Transfers from Restricted Funds	309,417	559,932
Total	2,149,534	6,927,587
FUNDS APPLIED:		
Additions to property, plant, and equipment — net	1,037,227	3,860,272
Reduction in long-term mortgage debt	6,202	72,004
Payment of notes payable to bank		1,865,000
Increase in trustee designated funds	168,529	448,890
Payment of refinancing costs	33,700	
Total	1,245,658	6,246,166
INCREASE IN WORKING CAPITAL	\$ 903,876	\$ 681,421
SUMMARY OF CHANGES IN THE COMPONENTS OF WORKING CAPITAL:		
Increase (decrease) in current assets:		
Cash	\$ 727,183	\$ 29,368
Temporary cash investments	367,600	288,899
Receivables (net)	640,287	245,641
Inventories	(21,269)	35,685
Prepaid expenses	35,034	(39,441)
Total	1,748,835	560,152
Decrease (increase) in current liabilities:		
Accounts payable, etc.	(900,861)	(238,046)
Deferred revenue	(65,027)	(1,960)
Current mortgage note instalments	65,802	13,677
Advances from third-party payors (Note 1)	55,127	(99,800)
Due to Restricted Funds		447,398
Total	(844,959)	121,269
INCREASE IN WORKING CAPITAL	\$ 903,876	\$ 681,421

See notes to financial statements.

Notes to Financial Statements

1. SIGNIFICANT ACCOUNTING POLICIES

The accompanying balance sheet of the Hospital is presented in two basic fund accountabilities of unrestricted and restricted funds, with inclusion of trustee designated funds and net property, plant, and equipment as separately identified components of unrestricted funds. Fund balances restricted by outside sources are included in restricted funds and are distinguished from unrestricted funds allocated to specific purposes by action of the Board of Trustees (trustee designated funds).

It is the consistent practice of the Hospital to record unrestricted legacies received as credits directly to the balance of unrestricted funds. Restricted gifts, grants, etc., and certain miscellaneous income from restricted resources are added to the appropriate restricted funds. Restricted special purpose funds, when expended for current operating purposes, are transferred to unrestricted funds and are reported as other operating revenue.

For purposes of comparison, certain prior year's amounts in the accompanying financial statements have been reclassified from amounts previously reported, including the reclassification to current liabilities of advances from third-party payors, previously netted against accounts receivable.

Other significant accounting policies are set forth in the financial statements and the notes which follow.

2. LAND, BUILDINGS, AND EQUIPMENT

Land, buildings, and equipment consist of the following:

	1973	1972
Land	\$ 468,946	\$ 468,946
Buildings	13,722,888	13,357,032
Fixed equipment	12,160,301	11,761,677
Major movable equipment	4,525,032	4,408,983
Total	30,877,167	29,996,638
Less accumulated depreciation	10,212,722	9,325,826
Land, buildings, and equipment — net	<u>\$20,664,445</u>	<u>\$20,670,812</u>

Depreciation is computed using the straight-line method over the estimated useful lives of depreciable assets. The Hospital uses accelerated depreciation methods to determine reimbursable costs under certain third-party reimbursement agreements. The additional revenue attributable to the excess of accelerated over straight-line depreciation is deferred and will be added to income when the depreciation timing differences reverse. Revenue thus deferred for the fiscal years ended September 30, 1973 and September 24, 1972 totaled \$72,000 and \$143,400, respectively.

3. LONG-TERM MORTGAGE DEBT

On November 8, 1973, the Massachusetts Health and Educational Facilities Authority (the Authority) sold \$14,900,000 principal amount of revenue bonds designated New England Deaconess Hospital Issue, Series A. The proceeds from the sale of the bonds are to be loaned to the Hospital for the purposes described below in accordance with the provisions of an Agreement and Mortgage dated as of October 2, 1973 between the Authority and the Hospital. The bonds are special obligations of the Authority payable from revenues of the Authority including mortgage payments paid to a trustee for the account of the Authority by the Hospital. With the exception of the Medical Office Building and certain staff residences, all of the Hospital's land and buildings (including contents), as well as all new facilities to be constructed from the proceeds of the financing, have been pledged as collateral in connection with the mortgage conveyed by the Hospital to the Authority. The Hospital has also granted to the Authority a first lien on gross receipts as additional security for payment of the mortgage indebtedness.

The proceeds to be received from the sale of the bonds will be used first to pay all existing long-term mortgage indebtedness of unrestricted funds as of November 8, 1973; therefore, only the principal amount of long-term mortgage debt, \$6,202, paid by the Hospital during the period from October 1, 1973 through November 8, 1973 is reported as a current liability of unrestricted funds in the accompanying financial statements. The remaining proceeds will be used for construction of a Clinical Laboratory and Radiation Therapy Facility and for purchase of specialized equipment, as well as for funding of miscellaneous debt service requirements and payment of certain legal and other expenses of the financing.

The Agreement and Mortgage provides for payment by the Hospital of annual principal payments or sinking fund instalments ranging from \$450,000 in 1976 to \$525,000 in 2005 and interest payments commencing on December 15, 1973 at rates which vary from 4.60% to 5.70% over the lives of the bonds.

Notes to Financial Statements Continued

4. MORTGAGE NOTE PAYABLE

The endowment funds mortgage note is payable in instalments through January 1991, including \$89,550 due within one year. The Hospital's Medical Office Building is assigned as collateral under the terms of this mortgage.

5. EMPLOYEES' RETIREMENT PLAN

The Hospital has a non-contributory retirement plan covering substantially all full-time employees not over age 55 at date of employment. Provision for pension costs aggregating \$575,000 and \$444,000 for the fiscal years ended September 30, 1973 and September 24, 1972, respectively, has been made in the accompanying financial statements for the funding of current normal costs and amortization of unfunded actuarial liability over a forty-year period. Substantially all such amounts provided have been paid to the trustee of the plan.

6. ECONOMIC STABILIZATION PROGRAM

Regulations of the Economic Stabilization Program presently impose limitations upon increases in revenues, profit margins and allowable costs of hospitals. Based upon the regulations published to date, management is of the opinion that the Hospital is in compliance with the Program.

Auditors' Opinion

New England Deaconess Hospital:

We have examined the balance sheet of New England Deaconess Hospital as of September 30, 1973 and the related statements of revenues and expenses, changes in fund balances, and changes in financial position of unrestricted funds for the fiscal year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

It is the consistent practice of the Hospital to record unrestricted legacies received as credits directly to the balance of unrestricted funds. The Hospital Audit Guide published by the Committee on Health Care Institutions of the American Institute of Certified Public Accountants, in setting forth generally accepted accounting principles for hospitals, states that unrestricted legacies received are to be recorded as non-operating revenue. During the year ended September 30, 1973, unrestricted legacies received by the Hospital aggregated \$286,834. Had the Hospital recorded these receipts as non-operating revenue, an excess of revenues over expenses of \$168,758 would have been reported in the Hospital's financial statements for the fiscal year ended September 30, 1973.

In our opinion, except for the effects of crediting unrestricted legacies received directly to unrestricted fund balances, as described in the preceding paragraph, the accompanying financial statements present fairly the financial position of New England Deaconess Hospital as of September 30, 1973 and its revenues and expenses, changes in fund balances, and changes in the financial position of its unrestricted funds for the fiscal year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Boston, Massachusetts
November 16, 1973

Hasbans & Sells



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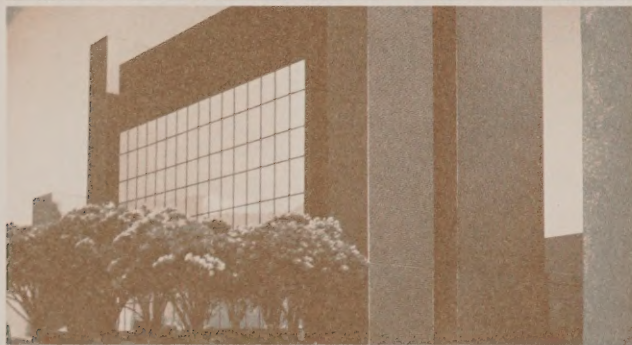
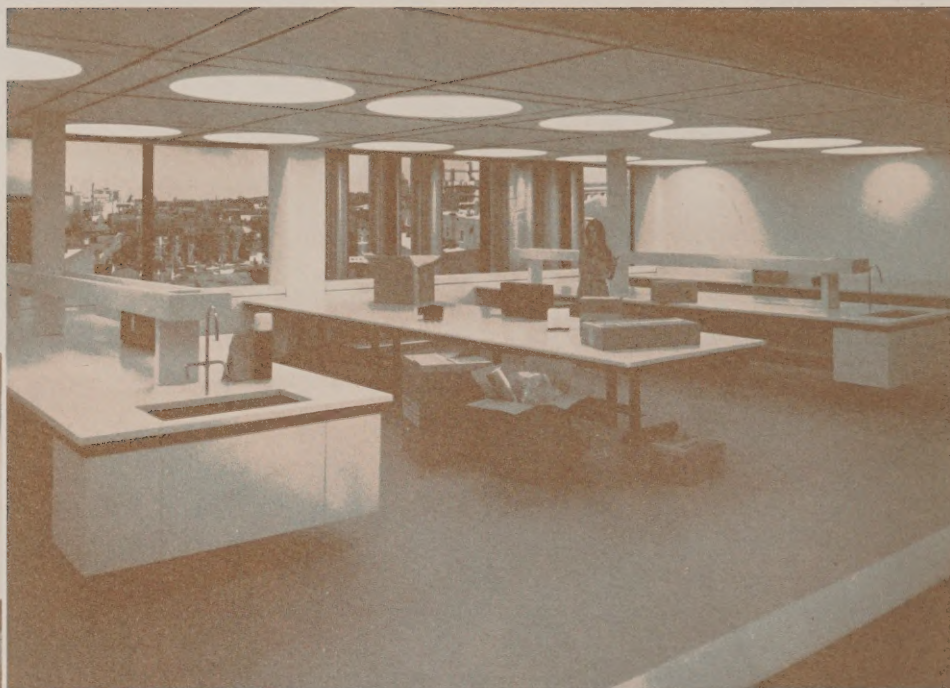
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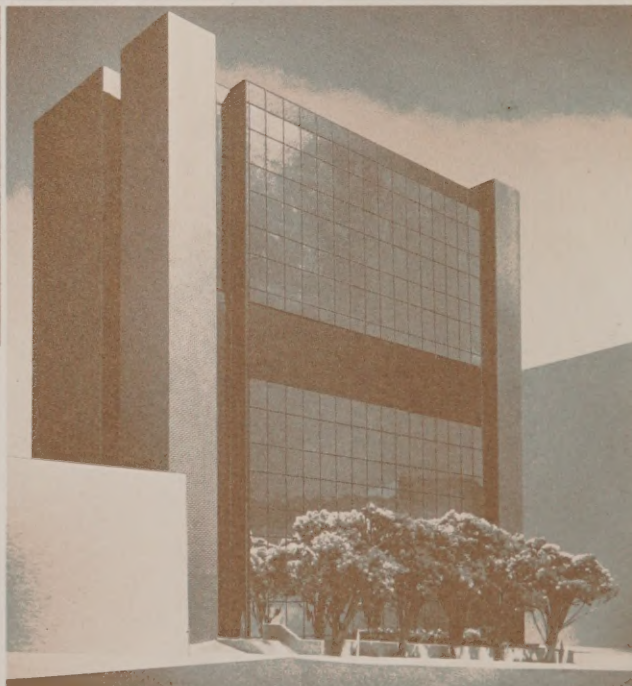
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